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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45 + 01/04/13

PRINTED: 12/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44E200	A. BUILDING _____ B. WING _____	11/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELBROOK SANITARIUM	114 CAMPUS DRIVE DAYTON, TN 37321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey and complaint investigation #32769 were completed on November 13 - November 20, 2013, at Laurelbrook Sanitarium. Deficiencies were cited related to complaint investigation #32769.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of facility policy, and interview, the facility failed to assess for self administration of medication for one resident (#56) of thirty-one residents reviewed. The findings included: Resident #56 was admitted to the facility on November 11, 2013, with diagnoses including Congestive Heart Failure and history of Aspiration Pneumonia. Medical record review of the November 2013 Physician's Orders revealed the resident was to receive nebulizer treatments of Albuterol Sulfate (bronchodilator) every four hours for shortness of breath. Medical record review revealed no documentation the resident had been assessed for self	F 176	F 176 483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE 1) The Nursing Supervisor completed a self administration assessment on Resident #56 on 11/20/13. Resident was unable to administer medication. LPN #3 was counseled on the proper administration of nebulizer treatments of Albuterol Sulfates on residents who have not been assessed to administer their medication. (See attached policy for Nebulizer Treatment) Exhibit # 1 2) The DON/Nursing Supervisor reviewed all residents receiving Nebulizer treatments for proper administration of Nebulizer treatments by staff. There were 3 residents receiving Nebulizer treatments. In-services were conducted on 11/20/13 & 11/21/13 by the DON for all licensed staff on Administration of Medication i.e. Nebulizer Treatments and when residents can self administer medication	12/25/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Keith Wilson RN — TITLE: Administrator — (X6) DATE: 12/25/13

* deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 176	Continued From page 1 administration of medications. Observation on November 20, 2013, at 8:20 a.m., revealed the resident lying on the bed receiving a nebulizer treatment. Continued observation revealed no staff members present in or near the resident's room. Review of facility policy, Resident Self Administration of Medications, revealed "...The resident maintains cognitive ability to self administer the medication..." Interview on November 20, 2013, at 8:25 a.m., with Licensed Practical Nurse (LPN) #3 outside the resident's room confirmed the resident had not been assessed for self administration of medications. Interview on November 20, 2013, at 9:55 a.m., with the Director of Nursing, in the hallway revealed the resident was unable to self administer medications and confirmed the resident had not been assessed for self administration of medications.	F 176	i.e. only when the resident has an approved Assessment of Self Administration of Medication. Any nursing staff not attending the in-service on 11/20/13 or 11/21/13 will be in-serviced by the DON or Nursing Supervisor upon return to work and must complete a post test. 3) The Pharmacy Consultant and Nursing Supervisor will monitor medication Pass on a random basis each month of each licensed nurse working on a medication cart noting compliance with medication Administration. (See attached monitoring sheet.) Exhibit # 2 4) Beginning 12/30/13 the DON will report the monitoring outcomes of Medication Pass Observations at the QAPI Committee meeting. The Administrator will report monitoring outcomes at the quarterly Governing Body meeting.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of facility policy, and interview, the facility	F 221	**F221 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS** 1) On 11/15/13 the DON obtained a new Consent from the family for the restraint and completed a new Pre-restraint assessment form for Resident #9. Exhibit # 3 Please note that the previous consent was obtained 5/28/12. Exhibit # 4	12/25/13

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F 221	Continued From page 2 failed to complete an assessment and obtain a consent for restraints for one resident (#9) of six residents reviewed for restraints of thirty-one residents reviewed. The findings included: Resident #9 was admitted to the facility on January 20, 2009, with diagnoses including Cerebral Vascular Accident, Intellectual Disabilities, Depression, Severe Mental Retardation, Aggression, and Convulsions. Medical record review of a Care Plan dated August 14, 2013, revealed "...Broda chair with attached thigh straps daily use...ensure thigh straps are correctly applied and secured...clip alarm on at all times...monitor position in chair/bed..." Medical record review of a quarterly Minimum Data Set (MDS) dated October 3, 2013, revealed the resident was severely impaired for daily decision making, had psychomotor retardation, had physical behaviors 1-3 days a week, rejected care 1-3 days a week, was totally dependent on staff for all Activities of Daily Living (ADL's), had had no falls since the prior assessment, used a limb restraint and chair to prevent from rising. Medical record review of the Physician's Recapitulation Orders dated November 2013 revealed "...restraint monitoring...Broda (Broda) chair with hip restraints..." Medical record review of the chart revealed no consent or restraint assessment for the Broda chair or thigh straps.	F 221	2) On 11/20/13 the DON & Nursing Supervisor checked all residents with restraints for consents and Pre-restraint assessments. All other residents with restraints had consents and Pre-restraint assessments. On 11/20/13 the DON conducted in-services with all nursing staff (RNs, LPNs, CNAs) on the policy of Restraint Management and documentation of care provided. Any nursing staff not attending on 11/20/13 will not be allowed to work until they are in-serviced by the DON or Nursing Supervisor prior to their scheduled shift. 3) Beginning 12/1/13 the Nursing Supervisor will monitor restraints weekly and report outcomes to the DON on a special monitor form for a period of 3 months. Exhibit # 5 4) Beginning 12/30/13 the DON will report the outcomes of Restraint monitoring at the QAPI Committee meetings. The Administrator will report monitoring outcomes at the quarterly Governing Body meeting.	

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F 221	Continued From page 3 Observation on November 13, 2013, at 10:35 a.m., in the Activity Room revealed the resident in a Broda chair with thigh straps in place. Review of facility policy, Restraint Policy, no date revealed "...Definition of a restraint any...equipment or device...attached to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body...each resident will have a restraint evaluation...restraint consent must be signed by resident or responsible party..." Interview with the MDS Coordinator on November 15, 2013, at 1:15 p.m., in the MDS office confirmed no consent or assessment had been completed for the use of the Broda chair or thigh straps as a restraint. Interview with Certified Nurse Assistant (CNA) #3 on November 20, 2013, at 9:35 a.m., in the hall revealed the resident attempted to exit the Broda chair daily. Interview with CNA #4 on November 20, 2013, at 9:40 a.m., in the hall revealed the resident attempts to exit the chair and walks with two restorative aides. Interview with the Assistant Director of Nursing (ADON) on November 20, 2013, at 9:28 a.m., at the Nurse's Station, confirmed the resident rocked in the Broda chair and if the chair was not reclined and without the thigh straps the resident would exit the chair. Interview with the Director of Nursing (DON) on November 15, 2013, at 2:35 p.m., in the	F 221		

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F 221	Continued From page 4 Conference Room confirmed the facility had failed to obtain consent and complete a restraint assessment for the Broada chair and the thigh straps for resident #9.	F 221		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on review of employee files, review of facility policy, and interview, the facility failed to check the abuse registry prior to hiring four employees for four of six employee files reviewed. The findings included: Review of six employee files for abuse screening revealed the facility had no documentation the abuse registry had been checked prior to hiring for four of six employees files reviewed. Review of facility policy, Preventing Resident Abuse, no date revealed "...investigations to prevent hiring persons...who have had a finding...entered into the nurse aide registry..." Interview with the Administrator on November 15, 2013, at 2:30 p.m., in the Conference Room confirmed the facility had failed to check the abuse registry for four of six employees prior to	F 226	F 226 483.13(c) DEVELOP/IMPLEMENT/ABUSE/ NEGLECT, ETC POLICIES 1) On 11/15/13 the Administrative staff person checked the abuse registry of the 4 employees who had missing abuse registry information. On 11/16/13 the Administrator counseled the assigned staff person who failed to check the abuse registry per facility policy. 2) On 11/16/13 the administrative staff responsible for personnel files checked all other employee files for abuse registry information. No other files were non-compliant. 3) Beginning 12/1/13 the administrator will monitor every new employee file for abuse registry information. A checklist was developed for the Administrative staff to use to ensure all information has been obtained. Exhibit # 6	12/25/13

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			4) Beginning 12/30/13 the Administrator will report the outcomes of Personnel file reviews at the QAPI Committee meetings. The Administrator will then report monitoring outcomes at the quarterly Governing Body meeting	

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F 226	Continued From page 5 hiring.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to promote dignity and respect by failing to provide incontinence care during a physician's appointment out of the facility for one resident (#36) of thirty-one residents reviewed. The findings included: Resident #36 was admitted to the facility on March 7, 2011, with diagnoses including Cerebral Edema, Anxiety, Hypertension, Diabetes Mellitus, Seizures, and Muscular Atrophy. Medical record review of the Care Plan dated August 14, 2013, revealed an area of potential for skin breakdown due to reduced mobility. Interventions included: an air mattress provided by the facility, monitor skin for S/S (signs and symptoms) of breakdown, alert charge nurse if (breakdown) observed, for notification of physician as needed for treatment orders, turn and reposition every two hours, and total assist with dressing, bathing, personal hygiene, and ambulation.	F 241	F 241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 1) On 11/15/13 the Administrator & DON reviewed and revised the facility policy on Quality of Life-Dignity and added a section on residents who are dependent on ADLs and are incontinent of Bowel and Bladder must be accompanied by a family member or CNA when transported to another agency for services. (See Attached Policy – Quality of Life Dignity) Exhibit # 7 On 11/20/13 the Nursing staff (RNs, LPNs, CNAs) and transport staff were in-serviced by the Administrator and DON on the revised policy – Quality of Life –Dignity. Any staff not attending the in-service will not be allowed to work until they have attended an in-service conducted by the DON or Nursing Supervisor. The Administrator will add to the transportation log a column to acknowledge the attendance of a family member or a CNA with the resident on any trips to an outside agency. This will be completed by 12/1/13. Exhibit # 8	12/25/13

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F 241	Continued From page 6 Medical record review of the quarterly Minimum Data Set (MDS) dated September 19, 2013, revealed the resident was moderately impaired for daily decision making, had no behaviors, no unhealed pressure ulcers, and was totally dependent on staff for all Activities of Daily Living (ADL's). Medical record review of a Nurse's Note dated October 23, 2013, revealed "...resident called this nurse to...room to complain about md (doctor) visit earlier in the day resident stated that...had a bowel movement on the way to...appointment today and did not get changed until...returned to the facility 6 hours later. This nurse asked the resident why no one changed the resident and...stated only the driver went with (resident) to the appointment..." Observation on November 13, 2013, at 7:40 a.m., in the resident's room revealed resident #36 lying in the bed with the breakfast tray on the overbed table. Interview with Licensed Practical Nurse (LPN) #1 on November 13, 2013, at 1:00 p.m., at the Nurse's Station revealed the resident left the facility in the facility van on October 23, 2013, at 1:00 p.m., for an apointment at 2:00 p.m., (one hour away from the facility) and the resident returned at 6:00 p.m. with no incontinent care while away from the facility. The driver was not a Certified Nurse Assistant (CNA) and the facility did not send a CNA to accompany the resident on the van ride to the physician's appointment. Interview on November 13, 2013, at 2:06 p.m., at the Nurse's Station, with LPN #8, (the nurse on duty when the resident returned to the facility	F 241	2) Effective 12/1/13 the DON/Nursing Supervisor/Charge nurse will assess all residents being transported to an outside agency for the need of a CNA to accompany the resident. A note will be recorded in the nursing notes of the assessment. 3) Beginning 12/1/13 the Nursing Supervisor will monitor the transport log and nursing notes for compliance with the policy and report to the DON weekly any non-compliance. 4)) Beginning 12/30/13 the DON will report the outcomes of the Transportation log and nursing note monitoring at the QAPI Committee meetings. The Administrator will report monitoring outcomes at the quarterly Governing Body meeting.	

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F 241	Continued From page 7 from the appointment on October 23, 2013) revealed when returned at 6:00 p.m. to the facility, the resident reported had been incontinent of bowels prior to arriving at the physician appointment. Continued interview revealed the CNA on duty upon the resident's return to the facility had provided incontinence care when the resident returned to the facility. Further interview revealed LPN #6 did not complete a skin assessment on October 23, 2013, and no problems with skin integrity were reported by the CNA's. Interview with CNA #2 on November 13, 2013, at 3:35 p.m., in the Conference Room revealed when the resident returned to the facility from a physician appointment on October 23, 2013, at 6:00 p.m., the resident had been incontinent of bowel and bladder on return to the facility. Continued interview revealed the resident was upset and reported the incontinent episode occurred prior to arriving at the physician's office. Continued interview revealed the resident's buttocks were red at that time but had no open areas. Continued interview revealed the resident's buttocks were usually red and were no different than usual. Interview with the resident on November 14, 2013, at 9:20 a.m., in the resident's room revealed the resident arrived at the doctor's office after an incontinent episode of the bowels and it made the resident feel "horrible and dirty." The resident stated "I have a lot of trouble with my colon." Interview with the van driver on November 14, 2013, at 3:05 p.m., in the conference room revealed the resident informed the driver of an	F 241		

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F 241	Continued From page 8 incontinent episode of bowels before the physician appointment. Continued interview revealed the driver had not been trained to provide "that kind of care," and the driver had nothing to provide the nurses at the physician's office to assist the resident with incontinence care. Interview with the Administrator on November 15, 2013, at 2:00 p.m., in the conference room revealed the facility had failed to send a CNA with a dependent resident to a physician's appointment out of the facility and had failed to promote dignity and respect by failing to provide incontinence care during a physician's appointment out of the facility for resident #36. C/O #32789	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to allow one resident (#36) the choice to eat meals out of the bed of thirty-one residents reviewed. The findings included:	F 242	F 242 483.15(b) SELF-DETERMINATION- RIGHT TO MAKE CHOICES 1) On 11/20/13 the DON counseled CNA # 3 concerning resident # 36's choice to eat her meals out of bed. Beginning 11/20/13 resident # 36 received her meals per her choice. 2) Beginning 11/20 – 11/22/13 the DON, Nursing Supervisor, and MDS coordinator reviewed all resident care guides for correct reflection of resident preferences for meals. An in-service with all CNAs and licensed staff was conducted on the	12/25/13

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F 242	Continued From page 9 Resident #36 was admitted to the facility on March 7, 2011, with diagnoses including Cerebral Edema, Anxiety, Hypertension, Diabetes Mellitus, Seizures, and Muscular Atrophy. Medical record review of a quarterly Minimum Data Set (MDS) dated September 18, 2013, revealed the resident was moderately impaired for daily decision making, had no behaviors, no unhealed pressure ulcers, and was totally dependent for all Activities of Daily Living (ADL's). Medical record review of a care plan intervention dated September 19, 2013, revealed "...resident requests to be up at every meal...says that it helps with digestion..." Observation on November 13, 2013, at 7:40 a.m., November 14, 2013, at 9:20 a.m., November 15, 2013, at 7:45 a.m.,and November 19, 2013, at 7:45 a.m., in the resident's room, revealed resident #36 lying on the bed with the breakfast tray on the overbed table. Interview with resident #36 on November 14, 2013, at 9:20 a.m., in the resident's room revealed the resident lying on the bed with the breakfast tray on the overbed table. Continued interview revealed the resident had requested to get out of bed for all meals. The resident complained the staff do not have time to get the resident up at breakfast and it is uncomfortable due to the residents neck and positioning. Interview with Certified Nurse Aide (CNA) #3 on November 14, at 9:30 a.m., in the resident's room revealed the staff had not had time to get the resident out of bed before trays came out.	F 242	importance of reviewing resident care guides and updating if conditions change or resident's preferences change. Also in-serviced on the following care guides – if resident preference is to eat meals out of bed then staff must follow the preferences. All nursing staff not attending the above in-service must attend an in-service conducted by the DON or Nursing Supervisor before reporting to work. 3) All residents will be interviewed by the Nursing Supervisor weekly for 9 weeks to ensure resident's meal preferences are respected. 4) Beginning 12/30/13 the DON will report the monitoring outcomes of resident preferences at the QAPI Committee meetings. The Administrator will report monitoring outcomes at the quarterly Governing Body meeting.	

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F 242	Continued From page 10 Interview with the Assistant Director of Nursing on November 19, 2013, at 9:00 a.m., at the Nurse's Station confirmed the facility had failed to allow the resident a choice to eat meals out of the bed.	F 242		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide one resident (#36), medically related social services to obtain a physician appointment and failed to provide a dental appointment for one resident (#50), of four residents reviewed for dental services of thirty-one residents reviewed. The findings included: Resident #36 was admitted to the facility on March 7, 2011, with diagnoses including Cerebral Edema, Anxiety, Hypertension, Diabetes Mellitus, Seizures, and Muscular Atrophy. Medical record review of a quarterly Minimum Data Set (MDS) dated September 19, 2013, revealed the resident was moderately impaired for daily decision making, had no behaviors, no unhealed pressure ulcers, and totally dependent for all Activities of Daily Living (ADL's).	F 250	F 250 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE 1) On 11/20/13 the Administrator counseled the Social Services Director for failure to comply with job duties for Resident # 36 and Resident # 50. On 11/25/13 the Social Services Director scheduled an appointment for a pap smear for Resident # 36 on the following date:12/17/13 and a Dental appointment for Resident # 50 for the following date: 11/25/13. 2) On 11/20 – 11/22/13 the Social Services Director interviewed each resident for needed appointments or other services. There were no residents needing appointments. 3) The Social Services Director will create a spreadsheet by 12/1/13 to monitor residents who receive request services. This will be maintained indefinitely by the Social Services Director. Exhibit # 9	12/25/13

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F 250	Continued From page 11 Medical record review of a Social Worker Note dated June 20, 2013, revealed "...resident requested appointment for Pap smear..." Observation on November 13, 2013, at 7:40 a.m., in the resident's room revealed resident #36 lying on the bed with the breakfast tray on the overbed table. Interview with resident #36 on November 14, 2013, at 9:20 a.m., in the resident's room revealed the resident lying on the bed with the breakfast tray on the overbed table. Continued interview revealed "would like to see a female doctor because I have a lot of trouble with infections." Interview with the Social Worker (SW) on November 14, 2013, at 2:30 p.m., in the Social Worker Office, confirmed the SW had not assisted the resident to make an appointment for a Gynecologist visit. Continued interview confirmed the facility had failed to arrange a Gynecologist appointment for the resident. Resident #50 was admitted to the facility on September 21, 2013, with diagnoses including Essential Hypertension, Peripheral Vascular Disease, Chronic Ischemic Heart Disease, and Hyperlipidemia. Observation of the resident on November 18, 2013, at 2:23 p.m., in the resident's room revealed the resident had some missing upper teeth. Medical record review of the resident's Comprehensive Care Plan dated October 3,	F 250	4) Beginning 12/30/13 the Social Services Director will report the monitoring outcomes of Dental Services or other services requested at the QAPI Committee meetings. The Administrator will report monitoring outcomes at the quarterly Governing Body meeting.	

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F 250	Continued From page 12 2013, and revised on October 7, 2013, revealed the resident had a dental health problem related to poor oral hygiene with an intervention of "...coordinate arrangements for dental care, transportation as needed/as ordered..." Interview with Licensed Practical Nurse (LPN) #1 on November 19, 2013, at 2:32 p.m., at the nursing station confirmed the resident had not been scheduled for a dental appointment. Interview with the Social Services Director on November 19, 2013, at 2:50 p.m., in the social services office revealed the duties of arranging dental services and transportation for residents for same were a responsibility of the social services department at the time of the MDS assessment, and confirmed the resident had not been scheduled for a dental appointment.	F 250		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of facility assignment, and interview, the facility failed to maintain an oxygen concentrator in a clean manner for one resident (#36) and failed to maintain a vinyl footrest for a Broda chair in a sanitary manner for one resident (#9), of thirty-one residents reviewed. The findings included:	F 253	F253 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES 1) On 11/18/13 upon being made aware of deficient practice the DON immediately cleaned the O2 concentrator of Resident # 36 and washed the filters and had housekeeping clean the vinyl footrest of the Broda Chair for Resident # 9. On 11/18/13 the DON reviewed the policy on Cleaning Patient Care Equipment and soiled furniture. On 11/20/13 the DON conducted an in-service with all nursing staff (RNs,	12/25/13

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F 253	Continued From page 13 Resident #38 was admitted to the facility on March 7, 2011, with diagnoses including Cerebral Edema, Anxiety, Hypertension, Diabetes Mellitus, Seizures, and Muscular Atrophy. Observation on November 18, 2013, at 2:46 p.m., in the resident's room revealed a oxygen concentrator with a heavy build up of dust and two filters with a heavy build up of dust on each side of the concentrator. Review of facility Staff Nurse 3rd Shift Duties, no date revealed "...every Friday remove filters and wash with soap and water clean the concentrator with a damp cloth..." Interview with the DON on November 18, 2013, at 2:47 p.m., in the resident's room, revealed the facility had a cleaning schedule for the concentrators. Continued interview confirmed the facility had failed to clean resident #38's oxygen concentrator and the filters had a heavy build up of dust and needed to be cleaned. Resident #9 was admitted to the facility on January 20, 2009, with diagnoses including Cerebral Vascular Accident, Intellectual Disabilities, and Severe Mental Retardation. Observation on November 18, 2013, at 11:05 a.m., in resident #9's room revealed the footrest of the resident's Broda chair in the bottom of the closet. Continued observation revealed the footrest had dried food particles, black debris, and mouse droppings on the vinyl footrest. Interview with the Director of Nursing (DON) on November 18, 2013, at 11:10 a.m., in the	F 253	LPNs, CNAs) on the facility policy for cleaning patient care equipment and furniture. All nursing staff not attending the above in-service will be in-serviced by the DON or Nursing Supervisor on equipment cleaning and cleaning soiled furniture before reporting to work. 3) The Administrator/DON will make rounds weekly to monitor O2 concentrators and furniture for cleanliness. Documentation of rounds will be done and outcomes reported at each QAPI meeting. 4) Beginning 12/30/13 the DON will report the monitoring outcomes of Patient care equipment and furniture cleanliness at the QAPI Committee meetings. The Administrator will report monitoring outcomes at the quarterly Governing Body meeting.	

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F 253	Continued From page 14 resident's room confirmed the vinyl footrest was "filthy." Continued interview confirmed the facility had failed to maintain the resident's footrest in a sanitary manner.	F 253		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy, review of facility investigation, and interview, the facility failed to update or revise the care plan after a fall for one resident (#31), failed to update the care plan to reflect the physical and speech therapy for one resident (#53), failed to update the care plan to reflect the discontinuation	F 280	F280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP Resident # 31 1) Upon being made aware of the deficient practice of failure to update a care plan **for Resident # 31**, the MDS Coordinator corrected the care plan on 11/20/13 to reflect the interventions from the fall of November 16, 2013. **Resident # 53's** care plan was corrected by the MDS Coordinator on 11/20/13 to reflect Physical Therapy and Speech Therapy that was ordered by the MD. **Resident # 36's** care plan was corrected by the MDS Coordinator on 11/20/13 to reflect the medication orders for Paxil and psychiatric evaluation and treat. Resident # 51's care plan was corrected by the MDS Coordinator on 11/20/13 to reflect weight loss. On 11/21/13 the Director of Nursing evaluated the process used by the MDS Coordinator to complete or update care plans. On 11/22/13 the process was revised by the DON to ensure timely	12/25/13

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F 280	Continued From page 15 of medication and a change in psychiatric treatment for one resident (#36), and failed to update the care plan to reflect weight loss for one resident (#51) of thirty-one residents reviewed. The findings included: Resident #31 was admitted to the facility on March 1, 2011, with diagnoses including Anxiety, Congestive Heart Failure, Depression, Cerebral Vascular Accident, and Dysphasia. Medical record review of the quarterly Minimum Data Set (MDS) dated September 12, 2013, revealed the resident had long and short term memory problems, was severely impaired for daily decision making, verbal and physical behaviors occurred 1-3 days a week, required extensive assistance for all Activities of Daily Living (ADL's), and used a trunk restraint and a chair to prevent from rising. Review of a facility investigation dated November 16, 2013, revealed "...resident observed in floor...steps taken to prevent recurrence: chair alarm to chair when up..." Medical record review of the Care Plan revealed no new intervention to address the resident's fall from the wheelchair. Review of facility policy, Fall Safety & Procedure, no date revealed "...Identify specific strategies for fall prevention in the care plan..." Observation on November 13, 2013, at 10:30 a.m., in the Activity Room revealed the resident sitting in a wheelchair with a seatbelt in place and a chair alarm in place.	F 280	completion and updates to care plans. 2) Beginning 11/25/13 the DON and MDS Coordinator reviewed care plans of all other residents to ensure care plans were current. This was completed on 11/29/13. 3) Beginning 12/1/2013 the DON will review five (5) care plans per month for accuracy and timeliness. If the Care Plan is delinquent, disciplinary action may be implemented. 4) Beginning 12/30/13 the DON will report the outcomes of Care Plan monitoring at the QAPI Committee meetings. The Administrator will report monitoring outcomes at the quarterly Governing Body meeting.	

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F 280	Continued From page 16 Interview with the Director of Nursing (DON) on November 19, 2013, at 1:08 p.m., at the Nurse's Station confirmed the facility had failed to update the care plan after the fall on November 16, 2013. Resident #53 was admitted to the facility on July 3, 2013, with diagnoses including Intracranial Hemorrhage, Chronic Respiratory Failure, Hypertension, Anxiety, and Aphasia. Medical record review of the quarterly Minimum Data Set (MDS) dated October 10, 2013, revealed the resident received Physical Therapy (PT), and Speech Therapy. Medical record review of the Care Plan dated July 11, 2013, revealed physical therapy to evaluate and treat and no focus, goal, and/or interventions for speech therapy. Medical record review of a Physician's Telephone Order dated August 8, 2013, revealed "...PT clarification orders: Pt (patient) to be seen by PT 2-3 x (times) week..." Medical record review of the Speech-Language Pathology Evaluation and Treatment Plan dated September 23, 2013, revealed "...Start date 9/23/13..." Observation on November 13, 2013, at 10:30 a.m., in the front lobby revealed the restorative aide exited the building with the resident and transport per wheelchair to therapy in the house next door. Interview with the Physical Therapist on November 14, 2013, at 1:00 p.m., in the	F 280		

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F 280	Continued From page 17 conference room revealed the resident received physical therapy in a house next door to the facility and received speech therapy at a stated hospital. Interview with the Director of Nursing (DON) on November 15, 2013, at 1:10 p.m., in the DON's Office confirmed the care plan was not revised or updated to reflect the physical therapy and/or speech therapy. Resident #36 was admitted to the facility on March 7, 2011, with diagnoses including Cerebral Edema, Depression, and Anxiety. Medical record review of the Care Plan dated August 14, 2013, revealed "...medicate as ordered with Prozac (antidepressant)...counseling sessions weekly via skype (video conferencing)..." Medical record review of the Physician's Recapitulation orders dated November 2013 revealed "...Paxil (antidepressant) 10 mg (milligrams) every other day and psych (psychiatric) to eval (evaluation) and treat..." Interview with the MDS Coordinator on November 15, at 1:20 p.m., in the DON's office confirmed the care plan had not been revised or updated related to the discontinuation of the Prozac and weekly counseling visits. Resident #51 was admitted to the facility on September 21, 2013, with diagnoses including Alcoholic Cirrhosis of Liver, Anemia, and Ascites. Medical record review of the care plan dated October 3, 2013, revealed "...Nutritional Status:	F 280		

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F 280	Continued From page 18 MD (Medical Doctor) has ordered regular diet..." Medical record review of the Nutrition/Dietary Note dated October 29, 2013, revealed "...regular diet, with fair-good po (by mouth) intake. Independent with eating. Resident has a butter pecan Ensure at supper...wt (weight) 2013: 9/13-200# (pounds); 10/13-175#...BMI (basal metabolic rate) 25.1 indicates overweight...Significant wt loss; related to fluid...Recommendations: NAS (no added salt) to current diet order..." Medical record review of the daily meal intake report dated October 2013 revealed the resident's average intake was 75 to 100%. Observation on November 20, 2013, at 7:30 a.m., revealed the resident seated in a wheelchair eating breakfast of cereal, toast, fruit, and milk. Interview with the Director of Nursing on November 19, 2013, at 2:10 p.m., in the conference room confirmed the care plan had not been updated to include the weight loss.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to follow a physician's order to check the pulse before medication administration for one resident (#18)	F 281	F281 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS Resident #18 1) Upon being made aware of LPN #2's deficient practice of administering Metoprotol medication without checking the pulse prior to administrating, the DON re-educated LPN # 2 on the correct policy "Administering Medications" emphasizing the	12/25/13

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F 281	Continued From page 19 and failed to obtain an order for a left hand splint for resident (#53) of thirty-one residents reviewed. The findings included: Resident #18 was admitted to the facility on September 1, 2011, with diagnoses including Hypertension, Cardiovascular Disease, and Diabetes Mellitus. Medical record review of the Physician's Recapitulation Orders dated November 2013 revealed "...Metoprolol (high blood pressure) 25 mg (milligrams) give one tablet by mouth two times a day...hold for pulse less than 60..." Medical record review of a Medication Administration Record (MAR) dated November 2013 revealed "...Metoprolol (high blood pressure) 25 mg (milligrams) give one tablet by mouth two times a day...hold for pulse less than 60..." Observation on November 18, 2013, at 3:50 p.m., in the resident's room revealed Licensed Practical Nurse (LPN) #2 administered Metoprolol 25 mg without checking the pulse. Interview with LPN #2 on November 18, 2013, at 4:00 p.m., in the dining room confirmed the LPN had failed to follow physician's orders to check the pulse prior to administration of the Metoprolol. Resident #53 was admitted to the facility on July 3, 2013, with diagnoses including Intracranial Hemorrhage, Chronic Respiratory Failure, Hypertension, Anxiety, and Aphasia. Medical record review of a Restorative Program	F 281	importance of checking the pulse prior to administration of antihypertensive mediation. This was done on 11/20/13. The DON will observe LPN # 2 randomly on a quarterly basis until no errors are noted. This was begun on 12/1/13. The Pharmacy Consultant will assist in medication observation for LPN # 2 and other nurses on a monthly basis beginning 12/3/13. 2) On 12/1/13 to 12/15/13 the DON or Nursing Supervisor or designee observed Licensed nurses passing medications on the above dates to ensure a pulse was checked prior to the medication being administered. On 12/3/13 the Pharmacy Consultant in-serviced all licensed staff on "Proper Med Pass Procedures" 3) Medication Pass will be observed by the DON or designee beginning 12/1/13 to ensure that the facility policy and state laws are observed. The Pharmacy consultant will assist in Med Pass observations of RNs & LPNs administering medications within the facility beginning 12/3/13.	

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F 281	Continued From page 20 Note dated July 8, 2013, revealed PT (Physical Therapy) recommends:...L (left) wrist extension/hand...orthotic..." Medical record review of the Physician's Recapitulation Orders dated November 2013 revealed no order for the left hand splint. Observation on November 13, 2013, at 11:30 a.m., in the resident's room revealed the resident lying on the bed with a splint on the left hand. Interview with Restorative Aide #1 on November 13, 2013, at 11:35 a.m., in the resident's room revealed the Restorative Aide placed the left hand splint on the resident in the morning and the Certified Nurse Assistant (CNA) removed the splint at night. Interview with the PT on November 14, 2013, at 1:00 p.m., in the conference room revealed the resident received physical therapy in a house next door to the facility. Continued interview revealed the resident was awaiting results of an orthotic appointment for splints. The PT placed the left hand splint on the resident on July 8, 2013. Interview with the Director of Nursing (DON) on November 15, 2013, at 1:10 p.m., in the DON's office confirmed the facility had failed to obtain a physician's order for the left hand splint.	F 281	The DON or designee will monitor medication administration to ensure resident's medications are administered correctly. This was begun on 12/1/13 and will continue monthly on a random basis until compliance has been achieved. 4) Beginning 12/30/13 the DON will report the outcomes of Med Pass monitoring at the QAPI Committee meetings. The Administrator will report monitoring outcomes at the quarterly Governing Body meeting. **Resident 53** 1) Upon being made aware that Resident # 53 did not have a physician order for the Left wrist splint the DON immediately called the doctor and wrote an order for the splint that had been placed on the resident's left wrist by Physical Therapy. An in-service was conducted by the Pharmacy Consultant on 12/3/13 on following up with the physician on recommendations from health care providers who provide services to the residents.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of	F 282		

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			On 12/25/13 all health care providers of service were requested per memo from DON to provide copies of any recommendations for resident care to the DON or Nursing Supervisor following their visit or treatment to the resident. 2) On 11/25/13 to 11/29/13 DON or Nursing Supervisor or designee checked all resident's charts for health care provider recommendations that had not been addressed. No other residents were identified as needing an order. On 12/25/13 the DON in-serviced all licensed staff on "Obtaining Physician review of Health Care Provider recommendations." 3) To ensure that the facility's policy and state laws are observed concerning physician orders for all medications/treatments, the Pharmacy consultant will assist with education and training on a monthly basis beginning 12/3/13. This will continue for 6 months or until substantial compliance has been achieved.	12/25/13

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			The DON or designee will monitor health care provider recommendations to ensure timely reviews by physician and orders are written when needed. This was begun on 12/15/13 and will continue monthly until compliance has been achieved. 4) Beginning 12/30/13 the DON will report the outcomes of monitoring Health Care Provider recommendations at the QAPI Committee meetings. The Administrator will report monitoring outcomes at the quarterly Governing Body meeting.	

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F 282	Continued From page 21 care. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to implement the Comprehensive Care Plan for dental services for one (#50) of thirty-one residents reviewed. The findings included: Resident #50 was admitted to the facility on September 21, 2013, with diagnoses of Essential Hypertension, Peripheral Vascular Disease, Chronic Ischemic Heart Disease, and Hyperlipidemia. Observation on November 18, 2013, at 2:23 p.m., in the resident's room revealed the resident had some missing upper teeth. Medical record review of the resident's comprehensive care plan dated October 3, 2013, and revised for dental health on October 7,2013, revealed the resident had a dental health problem r/t (related to) poor oral hygiene, with an intervention of "... coordinate arrangements for dental care, transportation as needed/as ordered..." Interview with the Minimun Data Set (MDS) Coordinator in the MDS office, on November 19, 2013 at 1 :35 p.m., revealed the Care Plan had been updated on October 7, 2013, for dental services and was not sure the need for dental services had been communicated to social services to implement.	F 282	**F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN** 1) Upon being made aware that dental health services had not been provided as noted in the Comprehensive Care Plan **for Resident # 50,** the Social Services Director arranged an appointment with a Dentist on 11-25-13. On 12/3/13 the DON met with the MDS Coordinator and Social Service Director on communication of identified resident care needs when assessments are completed. Beginning 12/11/13 the MDS Coordinator will provide a copy of any revised resident care plan to the Social Service Director who will initial and give to the DON. 2) Beginning 12/12/13 the MDS Coordinator and Social Services Director reviewed care plans of all other residents to ensure dental health services were provided when identified. This was completed on 12/13/13. 3) Beginning 12/15/2013 the DON will review all revised care plans that have been completed by the MDS Coordinator and sent to the Social Services Director for review and initialing. This will continue for 4 weeks.	12/13/13

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F 282	Continued From page 22 Interview with Licensed Practical Nurse (LPN) #1 on November 19, 2013, at 2:32 p.m., at the nursing station confirmed the resident had not been scheduled for a dental appointment.	F 282	4) Beginning 12/30/13 the DON will report the outcomes of Social Services Care Plan monitoring at the QAPI Committee meetings. The Administrator will report monitoring outcomes at the quarterly Governing Body meeting.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to properly position two residents (#9, #31) of thirty-one residents reviewed. The findings included: Resident #9 was admitted to the facility on April 17, 2009, with diagnoses including Cerebral Vascular Accident, Intellectual Disabilities, Depression, Severe Mental Retardation, Aggression, and Convulsions. Medical record review of a Care Plan dated August 14, 2013, revealed "...Broda chair with attached thigh straps daily use...ensure thigh straps are correctly applied and secured...clip alarm on at all times...monitor position in chair/bed..."	F 309	**F 309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** Resident # 9 1) Upon being made aware that staff had not provided proper leg support **for Resident # 9** on 11/18/13 the Director of Nursing immediately requested staff to provide leg support to Resident # 9 by placing the foot rest on the Broda chair and use of pillows. On 11/18/19 the DON added to the Resident care guide and care plan to check Resident # 9 every 2 hrs when resident in the Broda chair for proper leg support. On 11/23/13 the DON and/or Nursing supervisor met with the nursing staff (licensed staff and CNAs) on each shift to communicate the changes to the care plan of Resident # 9.	12/25/13

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F 309	Continued From page 23 Medical record review of a quarterly Minimum Data Set (MDS) dated October 3, 2013, revealed the resident was severely impaired for daily decision making, had psychomotor retardation, physical behaviors present 1-3 days a week, rejection of care 1-3 days a week, totally dependent on staff for all Activities of Daily Living (ADL's), total dependence for bed mobility, transfers, ambulation, no falls since prior assessment, limb restraint and chair to prevent from rising. Observation on November 13, 2013, at 10:35 a.m., in the Activity Room revealed the resident in a Broda chair with thigh straps in place, bilateral feet dangling with no support and no foot rest on the Broda chair. Observation on November 18, 2013, at 11:05 a.m., in the resident's room revealed the resident in the broada chair with the feet dangling. Continued observation revealed the footrest of the resident's chair in the bottom of the closet. Interview with the Director of Nursing (DON) on November 18, 2013, at 11:10 a.m., in the resident's room revealed the resident's feet were dangling and the footrest was in the bottom of the closet. Continued interview revealed the facility had failed to provide proper leg support for the dependent resident. Resident #31 was admitted to the facility on March 1, 2011, with diagnoses including Anxiety, Congestive Heart Failure, Depression, Cerebral Vascular Accident, and Dysphasia. Medical record review of the Minimum Data Set (MDS) dated September 12, 2013, revealed the	F 309	2) On 11/24/13 the Nursing Supervisor checked all residents in Broda Chairs for improper support to the legs and provided a report to the DON. Exhibit #5 On 12/3/13 the DON conducted an in-service for all nursing staff (RNs, LPNs, and CNAs) on resident care needs i.e. leg support in a Broda chair. All nursing staff not attending the above in-service must attend an in-service conducted by the DON or Nursing Supervisor before reporting to work. 3) Beginning 12/1/13 the DON will monitor Residents using Broda Chairs to ensure q 2 hr checks are done and quarterly assessments are completed. This will continue for 3 months or until QAPI approves a decrease in monitoring. 4) Beginning 12/30/13 the DON will report the outcomes of Broda Chair monitoring at the QAPI Committee meetings. The Administrator will report monitoring outcomes at the quarterly Governing Body meeting. **Resident #31** 1) Upon being made aware that staff had not provided proper support for **Resident # 31** on 11/19/13 the Director	

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F 309	Continued From page 24 resident has long and short term memory problems, severely impaired for daily decision making, verbal and physical behaviors occurred 1-3 days a week, required extensive assistance for all Activities of Daily Living (ADL's), and trunk restraint and chair to prevent from rising. Medical record review of the Care Plan dated September 9, 2013, revealed "...during meals place in upright position supporting the head and upper torso..." Observation on November 13, 2013, at 10:30 a.m., in the Activity room revealed the resident sitting in a wheelchair with a seatbelt in place, bilateral feet not on foot pedals, feet dangling with no support, and the chair tilted in a backwards position. Observation on November 19, 2013, at 8:10 a.m., in the small dining room revealed the resident reclined in a wheelchair with breakfast tray in front of the resident. Continued observation revealed the resident's feet not on foot pedals and had no support. Interview with the Activity Director on November 19, 2013, at 8:12 a.m., in the small dining room confirmed the resident was reclined in the chair, unable to reach the plate, and the resident's feet were dangling with no support. Interview with the DON on November 19, 2013, at 1:20 p.m., at the Nurse's Station, confirmed the resident had not been evaluated for positioning "in a long time." Continued interview confirmed the resident could benefit from a physical therapy evaluation for positioning. Further interview confirmed the facility had failed to maintain proper	F 309	of Nursing immediately requested staff to maintain the support to Resident # 31 by placing in an upright position during meals. On 11/20/19 the DON added to the Resident care guide and care plan to check Resident # 31 every 2 hrs when resident up in a chair for proper body support. On 12/3/13 the DON met with the MDS Coordinator to reeducate on the importance of communicating any modification of resident care plans to the nursing staff. Beginning 12/12/13 the MDS Coordinator will provide a memo to the nursing staff listing the names of resident with changes in their care plan. Each nursing employee must initial the memo to signify they are aware of care plan changes. After all nursing staff has initialed the memo the MDS Coordinator will keep all initialed memo that signifies staff are aware of resident's needs. On 11/23/13 the DON and/or Nursing supervisor met with the nursing staff (licensed staff and CNAs) on each shift to communicate the changes to the care plan of Resident # 31.	

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			2) On 11/24/13 the Nursing Supervisor checked all residents for improper support when sitting up in W/C as reflected on their care plan and provided a report to the DON. Exhibit 7 On 12/3/13 the DON conducted an in-service for all nursing staff (RNs, LPNs, and CNAs) on resident care needs i.e. body support when up in chair. All nursing staff not attending the above in-service must attend an in-service conducted by the DON or Nursing Supervisor before reporting to work. 3) Beginning 12/1/13 the DON will monitor Resident's support when up in chair to ensure q 2 hr check are done and proper support is being provided. This will continue for 3 months or until QAPI approves a decrease in monitoring. 4) Beginning 12/30/13 the DON will report the outcomes of monitoring appropriate support to residents when up in W/C at the QAPI Committee meetings. The Administrator will report monitoring outcomes at the quarterly Governing Body meeting.	

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F 309 F 312 SS=D	Continued From page 25 support for a resident dependent for all ADL's. 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide care for a dependent resident while out of the facility for a physician's appointment for one resident (#36) of thirty-one residents reviewed. The findings included: Resident #36 was admitted to the facility on March 7, 2011, with diagnoses including Cerebral Edema, Anxiety, Hypertension, Diabetes Mellitus, Seizures, and Muscular Atrophy. Medical record review of the Care Plan dated August 14, 2013, revealed an area of potential for skin breakdown due to reduced mobility. Interventions included: an air mattress provided by the facility, monitor skin for S/S (signs and symptoms) of breakdown, alert charge nurse if (breakdown) observed for notification of physician as needed for treatment orders, turn and reposition every two hours, and total assist with dressing, bathing, personal hygiene, and ambulation.	F 309 F 312	F 312 485.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 1) On 11/16/13 the Administrator & DON reviewed and revised the facility policy on Quality of Life-Dignity and added a section on residents who are dependent on ADLs and are incontinent of Bowel and Bladder must be accompany by a family member or CNA when transported to another agency for services. Exhibit # 6 On 11/20/13 the Nursing staff (RNs, LPNs, CNAs) and transport staff were in-serviced by the Administrator and DON on the revised policy – Quality of Life –Dignity. Any staff not attending the in-service will not be allowed to work until they have attended an in-service conducted by the DON or Nursing Supervisor. The Administrator will add to the transportation log a column to acknowledge the attendance of a family member or a CNA with the resident on any trips to an outside agency. This will be completed by 12/1/13. Exhibit # 7	12/25/13

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F 312	Continued From page 26 Medical record review of the quarterly Minimum Data Set (MDS) dated September 19, 2013, revealed the resident was moderately impaired for daily decision making, no behaviors, no unhealed pressure ulcers, and totally dependent on staff for all Activities of Daily Living (ADL's). Medical record review of a Nurse's Note dated October 23, 2013, revealed "...resident called this nurse to...room to complain about md (doctor) visit earlier in the day resident stated that...had a bowel movement on the way to...appointment today and did not get changed until...returned to the facility 6 hours later. This nurse asked the resident why no one changed the resident and...stated only the driver went with (resident) to the appointment..." Observation on November 14, 2013, at 1:55 p.m., in the resident's room revealed two CNA's assisting the resident to bed with a lift. Interview with Licensed Practical Nurse (LPN) #1 on November 13, 2013, at 1:00 p.m., at the Nurse's Station, revealed the resident left the facility in the facility van on October 23, 2013, at 1:00 p.m., for an appointment at 2:00 p.m., (one hour away from the facility) and the resident returned at 6:00 p.m. with no incontinent care while away from the facility. The driver was not a Certified Nurse Assistant (CNA) and a CNA did not accompany the resident. Interview with LPN #6 on November 13, 2013, at 2:05 p.m., at the Nurse's Station, (the nurse on duty when the resident returned to the facility from the appointment on October 23, 2013) revealed the resident reported when returned at 6:00 p.m. to the facility the resident had been	F 312	2) Effective 12/1/13 the DON/Nursing Supervisor/Charge nurse will assess all residents being transported to an outside agency for the need of a CNA to accompany resident. A note will be recorded in the nursing notes of the assessment. 3) Beginning 12/1/13 the Nursing Supervisor will monitor the transport log and nursing notes for compliance with policy and report to the DON Weekly any non-compliance. 4)) Beginning 12/30/13 the DON will report the monitoring outcomes of Transportation log and nursing note of transports of dependent and incontinence residents at the QAPI Committee meetings. The Administrator will report monitoring outcomes at the quarterly Governing Body meeting.	

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F 312	Continued From page 27 incontinent of bowel prior to arriving at the physician appointment. Continued interview revealed the CNA on duty provided incontinence care on arrival to the facility. Further interview revealed the LPN did not complete a skin assessment on October 23, 2013, and no problems with skin integrity was reported by the CNA's. Interview with CNA #2 on November 13, 2013, at 3:35 p.m., in the Conference Room revealed when the resident returned to the facility from a physician appointment on October 23, 2013, at 6:00 p.m., the resident had been incontinent of bowel and bladder. Continued interview revealed the resident had been upset and reported the incontinent episode occurred prior to arriving at the physician's office. Continued interview revealed the resident's buttocks were red at that time but had no open areas. Continued interview revealed the resident's buttocks were usually red and were no different than usual. Interview with the resident on November 14, 2013, at 9:20 a.m., in the resident's room revealed the resident arrived at the doctor's office after an incontinent episode of the bowels and it made the resident feel "horrible and dirty." The resident stated, "I have a lot of trouble with my colon." Interview with the van driver on November 14, 2013, at 3:05 p.m., in the conference room revealed the resident informed the driver of an incontinent episode of bowels before the physician appointment. Continued interview revealed the driver was not trained to provide "that kind of care" and the driver had nothing to provide the nurses at the physician's office to	F 312		

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F 312	Continued From page 28 assist the resident with incontinence care. Interview with the Administrator on November 15, 2013, at 2:00 p.m., in the conference room, revealed the facility had failed to send a CNA with a dependent resident to provide care during transportation to a physician's appointment.	F 312		
F 314 SS=D	C/O #32789 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of facility policy, and interview, the facility failed to complete a skin assessment after being made aware of an alteration in skin integrity for one resident (#36) of thirty-one residents reviewed. The findings included: Resident #36 was admitted to the facility on March 7, 2011, with diagnoses including Cerebral Edema, Anxiety, Hypertension, Diabetes Mellitus, Seizures, and Muscular Atrophy.	F 314	F 314 483.25(C) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Resident # 36 1) On 11/24/13 the DON reviewed the policy concerning CNAs reporting any positive findings observed while providing personal care to the resident such as skin breakdown must be reported immediately to charge nurse and policy on when to notify physician of a decline in health. On 12/3/13 the DON and/or Nursing Supervisor conducted in-services for all nurses (RNs, LPNS CNAs) on the CNAs responsibilities of reporting any skin breakdown and when to notify physician of a decline in health such as Stage II pressure ulcer.	12/25/13

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F 314	Continued From page 29 Medical record review of a quarterly Minimum Data Set (MDS) dated September 19, 2013, revealed the resident was moderately impaired for daily decision making, at risk for developing pressure ulcers, had no unhealed pressure ulcers, and was totally dependent for all Activities of Daily Living (ADL's). Medical record review of the Care Plan dated August 14, 2013, revealed "...potential for skin breakdown due to reduced mobility, air mattress provided by facility, monitor skin for S/S (signs and symptoms) of breakdown, alert charge nurse if (breakdown) observed for notification of physician as needed for treatment orders, turn and reposition every two hours, and total assist with dressing, bathing, personal hygiene, and ambulation..." Medical record review of a Braden Scale for Predicting Pressure Ulcers dated September 19, 2013, revealed "...high risk..." Medical record review of Physician Recapitulation order dated November 2013 revealed "...Zinc Oxide Cream (barrier cream) apply to buttocks/coccyx topically every shift for redness until resolved..." Observation with Certified Nurse Assistant (CNA) #3 on November 14, 2013, at 1:30 p.m., in the resident's room revealed the CNA transferring the resident with a lift. Continued observation during peri-care revealed an open area to the resident's buttocks. Review of facility policy, Skin and Wound Care, no date revealed "...Certified Nursing Assistants	F 314	On 11/15 a skin assessment was completed on Resident # 36 by Nursing Supervisor and Stage II wound was measured and noted in chart and physician was notified of the Stage II pressure ulcer. 2) On 11/21/13 the DON, Nursing Supervisor and/or charge nurse checked all resident's skin for skin breakdown. No other residents had skin breakdown. On 12/3/13 the DON conducted an in-service with all CNAs concerning the process of reporting to the Charge Nurse any wounds or any skin changes they note during the bath. Any CNA not attending will be in-service upon return to work by the DON and/or Nursing Supervisor. 3) Beginning 12/1/13 the wound care nurse will complete a Pressure Wound and a Non-Pressure Wound report every Friday to the DON. 4)) Beginning 12/30/13 the DON will report the monitoring outcomes of any skin breakdown and failure to report a decline in health to physician at the QAPI Committee meetings. The Administrator will report monitoring outcomes at the quarterly Governing Body meeting.	

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F 314	Continued From page 30	F 314		

will assess each resident in their care on an ongoing basis and report any changes to the...charge nurse..."

Interview with CNA #3 on November 14, 2013, at 1:35 p.m., in the resident's room, revealed the open area had been on the resident's buttocks and CNA #3 was unsure how long the open area had been present.

Interview with the Assistant Director of Nursing (ADON) on November 14, 2013, at 2:00 p.m., at the Nurse's Station revealed the ADON had assessed the resident's skin on November 12, 2013, and no alteration in skin integrity was observed. The ADON stated "will check resident when the resident goes back to bed."

Interview with CNA #2 on November 14, 2013, at 2:20 p.m., in the conference room revealed the "place" on the buttocks had not changed. The buttocks were often red.

Interview with Licensed Practical Nurse (LPN) #6 on November 14, 2013, at 2:40 p.m., at the Nurse's Station revealed the CNA's had not reported any changes in the resident's skin and LPN #6 was unaware of any alteration in skin integrity to the resident's buttocks. The Zinc Oxide is applied by the CNA's nightly and the LPN had worked the past three nights and had not provided any care or assessment to the resident's buttocks.

Interview with the ADON on November 15, 2013, at 7:30 a.m., at the Nurse's Station revealed the ADON had observed the resident's buttocks this morning (November 15, 2013), and a Stage Two ulcer was present. No assessment was

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F 314	Continued From page 31 completed on November 14, 2013, after being informed of an alteration in skin integrity and would call the physician when the office opened for new orders. Interview with the DON on November 15, 2013, at 10:00 a.m., in the conference room confirmed the facility had failed to complete a skin assessment on November 14, 2013, after being informed of an alteration in skin integrity, and had failed to notify the physician of a Stage Two pressure ulcer when identified on November 14, 2013.	F 314		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility investigation, observation, and interview, the facility failed to apply thigh straps correctly for one resident (#9), follow a care plan intervention for a clip alarm for one resident (#31), use a lift to transfer one resident (#36) and to place an overlap tray on a Geri-chair for fall prevention for one resident (#49) of four of six residents reviewd for accidents of thirty-one residents reviewed. The findings included:	F 323	F 323 483.25(h) FREE OF ACCIDENT/HAZARDS/SUPERVISION/DEVICES 1) On 11/23/13 the Director of Nursing met with all nursing staff (RNs, LPNs, and CNAs) concerning the importance of following the care plans for Residents # 9, # 31, # 36, and # 49. Each resident's care plan was reviewed with nursing staff and the deficient practice identified during recent survey: Resident # 9 - apply thigh straps correctly, Resident # 31 – Clip alarm when up in chair Resident # 36 - providing for a safe transfer by using lift Resident # 49 - place an overlap tray on the geri-chair	12/25/13

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F 323	Continued From page 32 Resident #9 was admitted to the facility on April 17, 2009, with diagnoses including Cerebral Vascular Accident, Intellectual Disabilities, Depression, Severe Mental Retardation, Aggression, and Convulsions. Medical record review of a Minimum Data Set (MDS) dated October 3, 2013, revealed the resident was severely impaired for daily decision making, psychomotor retardation, physical behaviors 1-3 days a week, rejection of care 1-3 days a week, totally dependent on staff for all Activities of Daily Living (ADL's), total dependence for bed mobility, transfers, ambulation, no falls since prior assessment, limb restraint and chair to prevent from rising. Medical record review of a Care Plan dated August 14, 2013, revealed "...Broda chair with attached thigh straps daily use...ensure thigh straps are correctly applied and secured...clip alarm on at all times...monitor position in chair/bed..." Observation on November 13, 2013, at 10:35 a.m., in the Activity Room, revealed the resident in a Broda chair with thigh straps in place. Review of a facility investigation dated September 27, 2013, at 4:30 p.m., revealed "...resident noted to be lying on left side in front of W/C (wheelchair)...redness noted to rt (right) lower leg...thigh straps loose res (resident) able to move out of chair..." Interview with the Director of Nursing (DON) on November 19, 2013, at 3:10 p.m., in the sunroom, confirmed the facility had failed to apply	F 323	All nursing staff not attending the above in-service must attend an in-service conducted by the DON or Nursing Supervisor before reporting to work. Beginning 12/1/13 the Nursing Supervisor will check Resident # 9, #31, # 36, and # 49 for compliance with care plan interventions and document in the medical record. 2) During the week of 11/20/14 to 11/26/13 the Nursing Supervisor checked all residents daily who had thigh strap restraints , alarms, using lifts, and overlap tray on geri-chairs to ensure care plans were followed. 3) Beginning 12/1/13 the DON/Nursing Supervisor/MDS Coordinator will monitor residents' care plans for any resident with thigh strap restraints, alarms, lifts used for transfer, and overlap tray on geri-chair for 3 months or until QAPI approves a decrease in monitoring. (See Attached) #5 4) Beginning 12/30/13 the DON will report the outcomes of care plan monitoring at the QAPI Committee meetings. The Administrator will report monitoring outcomes at the quarterly Governing Body meeting.	

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F 323	Continued From page 33 the thigh restraints correctly and the resident fell out of the chair. Resident #31 was admitted to the facility on March 1, 2011, with diagnoses including Anxiety, Congestive Heart Failure, Depression, Cerebral Vascular Accident, and Dysphasia. Medical record review of the MDS dated September 12, 2013, revealed the resident has long and short term memory problems, severely impaired for daily decision making, verbal and physical behaviors occurred 1-3 days a week, required extensive assistance for all ADL's, and trunk restraint and chair to prevent from rising. Medical record review of the Care Plan dated September 9, 2013, revealed clip alarm will be used when up in chair for resident safety Review of a facility investigation dated November 16, 2013, revealed "...resident observed in floor in front of w/c (wheelchair)..." Observation on November 13, 2013, at 10:30 a.m., in the Activity room revealed the resident sitting in a wheelchair with a seatbelt in place and a clip alarm. Interview with the Assistant Director of Nursing (ADON) on November 19, 2013, at 1:05 p.m., at the Nurse's Station revealed the resident did not have a clip alarm in place on November 16, 2013, when the resident fell out of the wheelchair. Interview with the DON on November 19, 2013, at 1:06 p.m., at the Nurse's Station confirmed the facility had failed to follow the care plan for a clip alarm.	F 323		

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F 323	Continued From page 34 Resident #36 was admitted to the facility on March 7, 2011, with diagnoses including Cerebral Edema, Anxiety, Hypertension, Diabetes Mellitus, Seizures, and Muscular Atrophy. Medical record review of a MDS dated September 19, 2013, revealed the resident was moderately impaired for daily decision making, no behaviors, and totally dependent for all Activities of ADL's. Medical record review of the Resident Plan of Care Instructions no date revealed "...Transfer: 2 person Maxi-Lift at all times..." Review of a facility investigation dated July 5, 2013, revealed the resident's foot caught in the side rail during a transfer by two Certified Nurse Aides (CNA). Observation on November 14, 2013, at 1:55 p.m., in the resident's room revealed two CNA's assisting the resident to bed with a lift. Interview with CNA #3 on November 15, 2013, at 2:00 p.m., in the resident's room revealed the CNA transferred the resident at the time of the accident on July 5, 2013. The CNA confirmed the staff failed to use the lift "it was quicker." Interview with the ADON on November 15, 2013, revealed the facility had failed to ensure a safe transfer. Resident #49 was admitted to the facility on August 20, 2013, with diagnoses including Dementia with Behaviors and Hypertension.	F 323		

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F 323	Continued From page 35 Medical record review of a quarterly MDS dated August 29, 2013, revealed short and long term memory problems, severely impaired for daily decision making, wandering daily, required supervision for ambulation, and one person physical assistance for ADL's. Medical record review of a Physician's Telephone order dated November 5, 2013, revealed "...May use Geri-Chair with overlap tray as needed for resident safety..." Medical record review of a care plan intervention dated November 5, 2013, revealed "...New order may use Geri-Chair with overlap tray for safety as needed consent signed..." Review of a facility investigation dated November 9, 2013, revealed the resident was sitting in the dining room in the Geri-chair. Staff found the resident in the floor next to the Geri-chair. Interview with the ADON on November 19, 2013, at 3:56 p.m., at the Nurse's Station confirmed on November 9, 2013, the resident did not have the overlap tray in place at the time of the fall. Interview with the DON on November 19, 2013, at 4:00 p.m., at the nurse's Station confirmed the facility had failed to follow a care plan intervention for an overlap tray on the Geri-chair for fall prevention and a physician's order for resident safety on November 9, 2013.	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332	F 332 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE	

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F 332	Continued From page 36 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to appropriately administer medications in two of twenty-seven opportunities resulting in a 7.4% medication error rate. The findings included: Observation on November 19, 2013, at 7:40 a.m., revealed Licensed Practical Nurse (LPN) #3 administering medications to resident #28. Continued observation revealed LPN #3 administered Novolog (insulin) 4 units subcutaneously into resident #28's left arm. Medical record review of the November 2013 Physician's Recapitulation Orders revealed "...Novolog (insulin)...inject 6 units subcutaneously in the morning related to DIAB (diabetes)..." Interview with LPN #3 on November 19, 2013, at 7:55 a.m., in the hallway confirmed the resident did not receive the correct dose of insulin. Observation on November 18, 2013, at 3:50 p.m., in the dining room revealed Licensed Practical Nurse (LPN) #2 prepared 10 units of Humalog insulin for administration for resident #18. Continued observation revealed the insulin was labeled opened October 12, 2013. Interview with LPN #2 on November 18, 2013, at 3:50 p.m., in the dining room confirmed the Humalog insulin was labeled opened October 12,	F 332	1) For Residents # 28 the Medical Doctor was notified of the medication error regarding the insulin error on November 18, 2013 and for Resident # 18 the Medical Doctor was notified of the medication error on November 19, 2013. LPN # 2 & # 3 were individually re-educated on Medication protocols and checking expiration dates prior to administration of drugs by the Director of Nursing. 2) On 12/3/13 the DON and/or the Nursing Supervisor observed med pass with all licensed nurses to ensure that Medication Administration is being conducted per medication protocol and in compliance of physician orders. The Director of Nursing and Pharmacy Consultant in-serviced all licensed nursing staff on 12/3/13 regarding Medication Administration Protocols and checking expiration date on drugs. All nursing staff not attending the above in-service must attend an in-service conducted by the DON or Nursing Supervisor before reporting to work.	12/25/13

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F 332	Continued From page 37 2013, and the insulin expired 28 days after the insulin was opened. Observation on November 18, 2013, at 3:53 p.m., revealed LPN #2 entered resident #18's room with the Humalog insulin labeled opened October 12, 2013. Interview with LPN #2 on November 18, 2013, at 3:53 p.m., in the resident's room confirmed the insulin expired 28 days after being opened and the insulin the LPN had prepared to administer was expired. Interview with the Consultant Pharmacist on November 20, 2013, at 12:30 p.m., by telephone confirmed Humalog insulin expired 28 days after opened, the expired insulin would loose it's "potency," and the risk of expired insulin would be a risk of high blood sugars.	F 332	3) The Director of Nursing/Nursing Supervisor/Pharmacy Consultant will observe med pass on a monthly basis for compliance with medication protocols. This will be monitored for 3 months or until substantial compliance. 4)) Beginning 12/30/13 the DON will report the outcomes of Medication monitoring at the QAPI Committee meetings. The Administrator will report monitoring outcomes at the quarterly Governing Body meeting.	
F 333 SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to prevent significant medication errors for two (#28, #18) of four residents observed for medication administration. The findings included: Observation on November 19, 2013, at 7:40 a.m., revealed Licensed Practical Nurse (LPN) #3	F 333	**F 333 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS** 1) 1) For Residents # 28 the Medical Doctor was notified of the medication error regarding the insulin error on November 18, 2013 and for Resident # 18 the Medical Doctor was notified of the medication error on November 19, 2013.	12/25/13

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F 333	Continued From page 38 administering medications to resident #28. Continued observation revealed LPN #3 administered Novolog (insulin) 4 units subcutaneously into resident #28's left arm. Medical record review of the November 2013 Physician's Recapitulation Orders revealed "...Novolog...inject 6 units subcutaneously in the morning related to DIAB (diabetes)..." Interview with LPN #3 on November 19, 2013, at 7:55 a.m., in the hallway confirmed the resident did not receive the correct dose of insulin. Observation on November 18, 2013, at 3:50 p.m., in the dining room revealed Licensed Practical Nurse (LPN) #2 prepared 10 units of Humalog insulin for administration for resident #18. Continued observation revealed the insulin was labeled opened October 12, 2013. Interview with LPN #2 on November 18, 2013, at 3:50 p.m., in the dining room confirmed the Humalog insulin was labeled opened October 12, 2013, and the insulin expired 28 days after the insulin was opened. Observation on November 18, 2013, at 3:53 p.m., revealed the LPN entered resident #18's room with the Humalog insulin (expired nine days ago). Interview with LPN #2 on November 18, 2013, at 3:53 p.m., in the resident's room confirmed the insulin expired 28 days after being opened and the insulin the LPN had prepared to administer was expired. Interview with the Consultant Pharmacist on	F 333	LPN # 2 & # 3 were individually re-educated on Medication protocols and checking expiration dates prior to administration of drugs by the Director of Nursing. For the month of December LPN #2 and LPN # 3 will be required to have another nurse check any insulin medications prior to administering the drug. 2) On 12/3/13 the DON and/or the Nursing Supervisor observed med pass with all licensed nurses to ensure that Medication Administration is being conducted per medication protocol and in compliance of physician orders. The Director of Nursing and Pharmacy Consultant in-serviced all licensed nursing staff on 12/3/13 regarding Medication Administration Protocols and checking expiration date on drugs. All nursing staff not attending the above in-service must attend an in-service conducted by the DON or Nursing Supervisor before reporting to work.	

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			3) The Director of Nursing/Nursing Supervisor/Pharmacy Consultant will observe med pass on a monthly basis for compliance with medication protocols. This will be monitored for 3 months or until substantial compliance. 4) Beginning 12/30/13 the DON will report the outcomes of Medication monitoring at the QAPI Committee meetings. The Administrator will report monitoring outcomes at the quarterly Governing Body meeting.	

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F 333	Continued From page 39 November 20, 2013, at 12:30 p.m., by telephone confirmed Humalog insulin expired 28 days after opened, the expired insulin would loose it's "potency", and the risk of expired insulin would be a risk of high blood sugars.	F 333		
F 354 SS=D	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on review of facility staffing and interview, the facility failed to ensure a Registered Nurse was on duty for eight consecutive hours on one of fourteen days reviewed. The findings included: Review of facility staffing from November 3-16, 2013, revealed a Registered Nurse was not on duty for eight consecutive hours on November 10, 2013. Interview with the Administrator on November 20,	F 354	**F 354 483.30b) WAIVER RN 8 HRS 7 DAYS/WK, FULL-TIME DON** 1) Effective 11/23/13 the all RN's in-serviced on the requirement for RN coverage. The DON will communicate to the Administrator when staffing does not meeting the minimum requirement of an RN per 24 hours. 2) Beginning 12/1/13 the DON/Nursing Supervisor will check the schedule daily to ensure RN coverage. Staffing schedules will be completed at least 2 weeks in advance to ensure adequate time to find RN coverage. 3) The Administrator will meet with the DON to review staffing schedules on a weekly basis for 4 weeks to discuss any staffing issues.	12/25/13

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			4) Beginning 12/30/13 the DON will report the outcomes monitoring of staffing at the QAPI Committee meetings. The Administrator will report monitoring outcomes at the quarterly Governing Body meeting.	

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F 354	Continued From page 40 2013, at 10:30 a.m., in the Administrator's office confirmed there was not a Registered Nurse on duty for eight consecutive hours on November 10, 2013.	F 354		
F 406 SS=D	483.45(e) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide physical, speech, and occupational therapy as ordered for one resident (#53) of three residents reviewed for rehabilitative services of thirty-one residents reviewed. The findings included: Resident #53 was admitted to the facility on July 3, 2013, with diagnoses including Intracranial Hemorrhage, Chronic Respiratory Failure, Hypertension, Anxiety, and Aphasia. Medical record review of the physician's admission orders dated July 3, 2013, revealed	F 406	**F 406 483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES** 1) Effective 11/23/13 residents admitted to facility for PT/OT/SLP with no insurance will be treated upon admission if ordered by physician. An in-service was conducted with all licensed staff, social services, and admission staff by the Administrator/Director of Nursing on following doctor's orders on admission for PT/OT/SLP if we are unable to meet the resident's needs the physician will be notified. 2) No resident will be denied admission if the facility can meet their needs regardless of financial status. 3) Effective 12/1/13 the Administrator will monitor each new admission for compliance with physician orders and financial status weekly.	12/25/13

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F 406	Continued From page 41 "...rehabilitation per facility Physical Therapy (PT)/Occupational Therapy (OT)/Speech Therapy (ST) Evaluation and Treatment per facility..." Medical record review of a Restorative Program Note dated July 8, 2013, revealed "...increased weakness on involved L (left) side, decreased AROM (active range of motion), and PROM (passive range of motion) in L side extremities and neck and trunk; decreased and totally dependent function for bed mobility, transfers, gait and balance. Pt (patient) is also developing flexion hand and wrist contracture as well as L ankle...Plan: PT recommends: 1) Resident receive PT care as soon as approved by insurance 2) Begin in house Restorative Care...the following equipment to promote joint mobility or functional mobility...L AFO L wrist extension/hand ext (extension) orthotic..." Medical record review of the Minimum Data Set (MDS) dated July 11, 2013, revealed no Physical Therapy, Occupational Therapy, and/or Speech Therapy. Medical record review of the Care Plan dated July 11, 2013, revealed physical therapy to evaluate and treat. Medical record review of a Restorative Program Note dated July 30, 2013, revealed the first treatment completed per physical therapy after the initial evaluation was completed on July 7, 2013 (twenty-seven days after the physician order). Medical record review revealed no occupational therapy notes.	F 406	4) Beginning 12/30/13 the DON will report the outcomes of monitoring physician orders on admission to ensure PT/OT/SLP are done at the QAPI Committee meetings. The Administrator will report monitoring outcomes at the quarterly Governing Body meeting.	

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F 406	Continued From page 42 Medical record review of the Speech-Language Pathology Evaluation and Treatment Plan dated September 23, 2013, revealed "...Start date 9/23/13...eighty-one days after physician order)" Observation on November 13, 2013, at 10:30 a.m., in the front lobby revealed the restorative aide exited the building with the resident in a wheelchair to escort to the therapy department in a house next door to the facility. Interview with Restorative Aide #1 on November 13, 2013, at 11:35 a.m., in the physical therapy department revealed the Restorative Aide had provided PROM and AROM to all extremities and positioning in the month of July 2013 prior to therapy starting. Interview with the Physical Therapist on November 13, 2013, at 2:25 p.m., in the Conference Room revealed the resident was placed on a restorative program on July 8, 2013, due to no insurance coverage for physical therapy (PT). The first PT treatment was August 2, 2013, (twenty-seven days after admission) when the resident received insurance. Interview with the Social Worker (SW) on November 14, 2013, in the Social Worker's Office revealed the SW applied for the resident's medicaid after admission to the facility. Interview with the Director of Nursing (DON) on November 15, 2013, at 2:30 p.m., in the conference room revealed the resident was admitted with orders for skilled nursing. The resident had orders on admission for PT/OT/ST, had not received OT since admission, speech therapy was started on September 23, 2013,	F 406		

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F 406	Continued From page 43 (eighty-one days after admission), and physical therapy was started on July 30, 2013, (twenty-seven days after admission). Continued interview revealed the resident had no insurance coverage for the therapies on admission and was approved on August 2, 2013, retroactive to the resident's admission date of July 3, 2013. The facility was aware on admission the resident had no insurance and the orders for PT/OT and ST. Further interview confirmed the facility had failed to provide rehabilitation to the resident.	F 406		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to provide dental services for one (#50), of thirty-one residents reviewed. The findings included: Resident #50 was admitted to the facility on September 21, 2013, with diagnoses of Essential Hypertension, Peripheral Vascular Disease, Chronic Ischemic Heart Disease, and	F 412	F 412 483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS 1) On 11/21/13 the Administrator re-educated the Social Service Director on her responsibilities in assisting residents who are in need of Dental Services. On 12 /3/13 an in-service was conducted by the DON with all nursing staff (RNs, LPNs, CNAs) concerning residents with missing or loose teeth to report to Social Services Director that there is a need for Dental Services. 2) Beginning 12/2/13 the MDS Coordinator and Social Services Director reviewed care plans of all other residents to ensure dental health services were provided when identified. This was completed on 12/3/13.	12/25/13

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F 412	Continued From page 44 Hyperlipidemia. Observation on November 18, 2013, at 2:23 p.m., in the resident's room revealed the resident had some missing upper teeth. Medical record review of the resident's comprehensive care plan dated October 3, 2013, and revised for dental health on October 7 ,2013, revealed the resident had a dental health problem r/t (related to) poor oral hygiene, with an intervention of "...coordinate arrangements for dental care, transportation as needed / as ordered..." Interview with Licensed Practical Nurse (LPN) #1 on November 19, 2013, at 2:32 p.m., at the nursing station confirmed the resident had not been scheduled for a dental appointment.	F 412	3) Beginning 12/5/13 the MDS Coordinator and Social Service Director will meet weekly to review any new interventions put in Resident Care plans to ensure needs are carried out as care planned. Beginning 12/12/2013 the DON will review all revised care plans that have been completed by the MDS Coordinator and sent to the Social Services Director for review and initialing. This will continue for 4 weeks.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation	F 425		

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			4) Beginning 12/30/13 the DON will report the outcomes of Social Services Care Plan monitoring at the QAPI Committee meetings. The Administrator will report monitoring outcomes at the quarterly Governing Body meeting.	

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F 425	Continued From page 45 on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to provide Paxil (an antidepressant) to one resident (#36) of thirty-three residents reviewed. The findings included: Resident #36 was admitted to the facility on March 7, 2011, with diagnoses including Cerebral Edema, Depression, and Anxiety. Medical record review of the Physician's Recapitulation orders dated September 2013 revealed Paxil 10 mg (milligrams) every other day. Medical record review of a Medication Administration Record (MAR) dated September 2013 revealed Paxil 10 mg give one tablet by mouth every other day, circled (as not administerd) on September 15, 2013, and next dose initialed as given on September 17, 2013 (three days since last dose given on September 13, 2013). Medical record review of the MAR revealed on September 16, 2013, the Paxil 10 mg was not available from the pharmacy. Interview with Licensed Practical Nurse (LPN) #1 on November 13, 2013, at 2:25 p.m., in the	F 425	F 425 483.60(a)(b) **PHARMACEUTICAL SVC – ACCURAE PROCEDURES, RPH** 1) On 12/3/13 the Administrator met with the Pharmacy Consultant to discuss the deficient practice of Pharmacy Services and expectation of Pharmacy Services. Effective 12/3/13 if a drug cannot be delivered timely by pharmacy services; the charge nurse will notify the physician to inform him/her that ordered drug is not available and request a possible alternate drug that is available until the initial ordered drug can be delivered. 2) On 12/3/13 the Pharmacy Consultant reviewed all new orders and MARs for timely delivery of any ordered drug. 3) The DON will add a Quality Indicator for Pharmacy Services to report monthly on timely delivery of all drugs needed for administering to residents.	12/25/13

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F 425	Continued From page 46 Conference Room confirmed the Paxil was not available from the pharmacy and the resident did not receive the scheduled dose of Paxil on September 15, 2013. Interview with the Director of Nursing (DON) on November 13, 2013, at 3:00 p.m., in the conference room confirmed the resident did not receive the scheduled dose of Paxil on September 15, 2013, and confirmed the facility had failed to provide pharmaceutical services for resident #36.	F 425	4) Beginning 12/30/13 the DON will report the outcomes of monitoring for timely delivery of medications at the QAPI Committee meetings. The Administrator will report monitoring outcomes at the quarterly Governing Body meeting.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked,	F 431	F 431 483.60(b)(d)(e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 1)On 11/20/13 LPN # 2 was re-educated by the Director of Nursing on "Administration of Medication" and Disposal of Medication. On 12/9/13 the administrator ordered sharps containers made to fit the med carts and can be locked. On 12/3/13 the Pharmacy Consultant and DON in-serviced all licensed staff (RNs, LPNs, CNAs) on Disposal of Medication and Storage of Medications.	12/25/13

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F 431	Continued From page 47 permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain insulin in a locked storage area and failed to dispose of outdated insulin in a safe manner. The findings included: Observation on November 18, 2013, at 3:53 p.m., in the dining room revealed Licensed Practical Nurse (LPN) #2 placed an insulin syringe and a bottle of Humalog insulin one-fourth full, on top of the medication cart and exited the dining room and entered the medication room. Interview with LPN #2 on November 18, 2013, at 3:55 p.m., in the dining room confirmed the LPN had failed to lock the insulin and syringe in the medication cart and residents were present in the dining room. Observation on November 18, 2013, at 4:00 p.m., in the dining room revealed LPN #2 disposed of a bottle of outdated insulin in the sharps container on the medication cart. Interview confirmed the LPN had disposed of the vial of Humalog insulin in the sharps container on the medication cart.	F 431	2) Beginning 12/1/13 the Director of Nursing &/or Nursing Supervisor will monitor for two weeks the Medication Cart for Compliance with Medication protocols including Disposal and Storage of Medications. 3) The Pharmacy Consultant and Director of Nursing will randomly monitor for compliance of the medication protocols for Disposal & Storage of Medication for 3 months 4) Beginning 12/30/13 the DON will report the outcomes of monitoring compliance of medication protocol – Disposal & Storage of medications at the QAPI Committee meetings. The Administrator will report monitoring outcomes at the quarterly Governing Body meeting.	

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F 431	Continued From page 48 Continued interview revealed the medication cart was stored in the dining room and the sharps container was not locked. Interview with the Director of Nursing (DON) on November 19, 2013, at 7:35 a.m., in the conference room revealed medications are to be locked in the medication cart at all times and the facility disposed of outdated insulin in the sharps container located on the medication cart. Continued interview revealed the facility had failed to maintain medications in a locked storage area before and after medications were dispensed. Interview with the Consultant Pharmacist on November 20, 2013, at 12:30 p.m., by telephone confirmed expired medications were to be placed in a box in the locked medication room and sent back to the pharmacy for proper disposal.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS Residents # 18, # 7 & # 57 1) On 12/3/13 LPN # 2 was re-educated by the Director of Nursing on Infection Control practices i.e. Disposal of sharps, proper cleaning and use of glucometer, & medication administration of Subcutaneous injections with use of gloves.	12/25/13

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F 441	Continued From page 49 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, observation, and interview, the facility failed to follow infection control practices during accuchecks (test to check blood sugar levels) for three residents (#18, #17, #57), standard universal precautions for sharps disposal and for contact with blood, and failed to follow infection control policy during the lunch meal in the main dining room. The findings included: Review of facility policy Medication-Syringe and Needle Disposal, no date revealed "...immediately after use...needles are placed in puncture resistant...containers..."	F 441	On 12/3/13 the DON conducted an in-service for all staff (RNs, LPNs, and CNAs) on Infection Control during Medication Administration. All nursing staff not attending the above in-service must attend an in-service conducted by the DON or Nursing Supervisor before reporting to work. The DON &/or Nursing Supervisor observed LPN # 2 administering drugs beginning 11/21/13 to 11/29/13 to ensure that LPN #2 was disposing of sharps in correct container, used the glucometer according to policy and wore gloves when administering injections. 2) Beginning 12/1/13 the Director of Nursing &/or Nursing Supervisor will monitor for two weeks Medication Administration and the Medication Cart for Compliance with Medication protocols including Disposal and Storage of Medications. 3) Beginning 12/15/13 the Director of Nursing , Nursing Supervisor &/or Pharmacy Consultant will monitor on a monthly basis each licensed nurse	

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	44E200	A. BUILDING _____ B. WING _____	11/20/2013

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F 441	Continued From page 50 Observation on November 18, 2013, at 3:23 p.m., in resident #18's room revealed Licensed Practical Nurse (LPN) #2 entered the resident's room with three black cloth containers containing accucheck machines and supplies labeled with resident #7, #18, and #57's name. Continued observation revealed LPN #2 placed the containers on resident #18's bedside table with a paper towel underneath the black cloth containers containing the machines. Observation on November 18, 2013, at 3:24 p.m., in resident #18's room, revealed LPN #2 performed an accucheck and disposed of the lancet (needle) in the trash can in the resident's room. Observation on November 18, 2013, at 3:27 p.m., in resident #7 and #57's room revealed LPN #2 entered the room with all three black cloth containers. Continued observation revealed LPN #2 placed the containers on resident #7's bedside table using the same paper towel used in resident #18's room. Observation on November 18, 2013, at 3:28 p.m., in resident #7's room revealed LPN #2 performed an accucheck and disposed of the lancet in the trash can in the resident's room. Observation on November 18, 2013, at 3:30 p.m., revealed LPN #2 placed all three of the accucheck machines on resident #57's bedside table stacked on top of each other with the same paper towel used on resident #18 and resident #7's bedside table. Observation on November 18, 2013, at 3:31 p.m.,	F 441	during medication administration to ensure sharps are disposed correctly, glucometers are used according to protocols i.e. cleaning in between each resident & use of gloves when administering injections. 4) Beginning 12/30/13 the DON will report the outcomes of Medication monitoring at the QAPI Committee meetings. The Administrator will report monitoring outcomes at the quarterly Governing Body meeting. **CNAs Infection Control Practice** 1) On 11/20/13 CNA # 1 was re-educated by the Director of Nursing on Infection Control practices when serving meal trays i.e. washing hands between residents. On 12/3/13 the DON/Nursing Supervisor conducted an in-service for all staff (RNs, LPNs, and CNAs) on Infection Control protocols when passing trays. All nursing staff not attending the above in-service must attend an in-service conducted by the DON or Nursing Supervisor before reporting to work.	

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F 441	Continued From page 51 in resident #57's room revealed LPN #2 performed an accucheck and disposed of the lancet in the trash can in the resident's room. Observation on November 18, 2013, at 3:35 p.m., in the dining room revealed LPN #2 placed the three black containers in the bottom drawer of the medication cart. Interview with LPN #2 on November 18, 2013, at 3:40 p.m., in the dining room confirmed LPN #2 had taken the resident's personal containers containing accucheck machines and supplies into resident's rooms and placed the containers on different resident's bedside tables without providing a clean barrier. Continued interview at this time confirmed the LPN placed the dirty lancets in the residents personal trash cans in the resident's room. Continued interview confirmed the facility had failed to maintain infection control and dispose of sharps in a safe manner. Observation on November 18, 2013, at 4:00 p.m., in resident #18's room, revealed LPN #2 administered insulin to resident #18 without wearing gloves. Interview with LPN #2 on November 18, 2013, at 4:03 p.m., in the dining room confirmed the LPN had failed to wear gloves while administering insulin to resident #8. Interview with the Director of Nursing (DON) on November 19, 2013, at 7:35 a.m., in the Conference Room confirmed gloves were to be worn while administering injections. Continued interview confirmed the facility had failed to follow infection control practices.	F 441	2) The DON &/or Nursing Supervisor observed CNA # 1 and all nursing staff during meal times on the following days 11/21/13 &11/27/13 to ensure that CNA # 1 and other nursing staff were washing hands after each meal tray served. 3) Beginning 12/15/13 the Director of Nursing &/or Nursing Supervisor will monitor for one month hand washing during meals for each meal time. 4) Beginning 12/30/13 the DON will report the outcomes of the monitoring of hand washing during meal times at the QAPI Committee meetings. The Administrator will report monitoring outcomes at the quarterly Governing Body meeting.	

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F 441	Continued From page 52 Observation of the main dining room lunch on November 18, 2013, from 11:24 a.m. until 11:26 a.m., revealed a Certified Nursing Assistant (CNA) #1 delivered meal trays to two separate residents in the main dining room and proceeded to make contact with two other residents and their personal belongings without washing the hands. Observation of CNA #1 on November 18, 2013, at 11:25 a.m., revealed the CNA delivered a meal tray from the dietary cart to resident #20 in the main dining room, touched the resident's stuffed animal, proceeded to make contact with resident #21, and delivered a second tray to resident #7, touched the resident's walker and prepared the resident's food, proceeded to go back to the dietary cart in an attempt to take another tray, without washing the hands. Review of facility policy "... Hand Hygiene: appropriate hand hygiene must be performed under the following conditions...5) after prolonged contact with a resident...8) after handling items or work surfaces potentially contaminated with a resident's blood, excretions, or secretions..." Interview with CNA #1 in the main dining room at 11:32 a.m., confirmed the hands were not washed between resident and personal belonging contacts during the dining observation in the main dining room.	F 441		
F 469 SS=E	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents.	F 469	F 469 483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM	12/25/13

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F 469	Continued From page 53 This REQUIREMENT is not met as evidenced by: Based on observation, review of a facility pest log, review of facility policy, and interview, the facility failed to maintain a facility free of pests in six of twenty-seven resident rooms. The findings included: Observation on November 18, 2013, at 10:55 a.m., in resident #35's room revealed a mouse in the left hand corner of the room. Continued observation revealed mouse droppings on the floor, on the nightstand, on the dresser, and in the bottom of the closet. Interview with the Director of Nursing (DON) on November 18, 2013, at 11:00 a.m., in resident #35's room confirmed mouse droppings on the resident's floor, nightstand, dresser, and the bottom of the closet. Observation on November 18, 2013, at 11:05 a.m., in resident #9's and #31's room revealed mouse droppings in the bottom of the closets and on the resident's dresser. Interview with the DON on November 18, 2013, at 11:10 a.m., in resident #9's and #31's room confirmed multiple mouse droppings in the bottom of the closet and on the resident's dresser. Interview with the Housekeeping Supervisor on November 18, 2013, at 2:05 p.m., at the Nurse's Station revealed November 16, 2013, resident #36 reported a mouse in the resident's room.	F 469	1) Beginning 11/18/13 the housekeeping Supervisor began cleaning the following rooms for mouse droppings in Resident's closet, dressers and floors: Resident room # 9, # 31, # 36, # 51, # 23, #25, Any reporting of mice in a room the Housekeeping Supervisor will place a mouse glue trap in the room and monitor until mouse is caught and will place a new mouse trap in room until no mice are caught up to 3 days. Exterminating company came out on 11/21/13 and replenished bait for traps outdoors and in the basement. They come monthly and as needed. 2) Beginning 12/1/13 the Housekeeping Supervisor will check and clean all resident's rooms that have mouse droppings in closet, dressers or on the floor. 3) The Housekeeping Supervisor will monitor for mouse dropping and mice on a weekly basis for two months and report to the QAPI Committee meeting. The Housekeeping Supervisor and staff will check traps daily and remove/replace as needed. Housekeeping staff have been in-serviced on this procedure.	

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F 469	Continued From page 54 The Housekeeping Supervisor placed a trap and caught a mouse in approximately four hours. Continued interview confirmed the supervisor had not checked other resident rooms for mouse or mouse droppings until November 18, 2013. Observation on November 18, 2013, at 2:15 p.m. revealed a mouse on a sticky trap in resident #51's room. Continued observation revealed the mouse was removed by a staff member. Observation and interview with resident #23, on November 18, 2013, in the resident's room at 2:40 p.m., revealed the resident's closet had rodent droppings present. Interview with the resident revealed "...had seen a mouse occasionally running around the room." Observation and interview with resident #25, on November 18, 2013, at 3:25 p.m., revealed the resident's closet had rodent droppings present. Interview with the resident revealed "...had seen a mouse occasionally running around the room, and was frightened by the rodents." Observation and interview with the Housekeeping Supervisor in the rooms of resident #23 and resident #25, on November 18, 2013, at 3:30 p.m., confirmed the rodent droppings were present in the two rooms. Review of a facility pest log revealed mice were noted in resident rooms on October 8, 21, 25, 29, 30, 31, 2013, and November 5, 2013. Interview with the exterminator on November 19, 2013, at 10:23 a.m., at the Nurse's Station confirmed the pest company visited monthly and placed exterior stations and stations in the	F 469	4) Beginning 12/30/13 the Housekeeping Supervisor will report the outcomes of the monitoring Infection Control for mouse droppings at the QAPI Committee meetings. The Administrator will report monitoring outcomes at the quarterly Governing Body meeting.	

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F 469	Continued From page 55 basement with bait for the mice. The bait is usually gone by the next visit. The exterminator states mouse droppings are sighted every visit.	F 469		